In November 2022, the Centers for Medicare & Medicaid Services (CMS) Innovation Center published a strategic vision for advancing value-based specialty care. While CMS’s largest model—the Medicare Shared Savings Program—has been primary care focused, the new strategy reflects an awareness that transitioning all Medicare beneficiaries into value-based care arrangements requires greater integration between primary and specialty care. Global capitation is one approach to achieving this objective. The most prominent example is Maryland’s global budget revenue (GBR) model, which centrally regulates reimbursement rates for all payers via a hospital-specific, prospectively set cap on total annual revenue across all care sites.

The GBR model has generated almost $1 billion in net savings for Medicare; the most among CMS’s alternative payment models. With other states seeking to implement global budgets, considering the effect of such reforms on specialty care is a policy priority, especially because 95% of Medicare expenditures are attributed to care beyond primary care. We describe surgical care under Maryland’s GBR model to identify lessons for how global budgets might reorient the organization, financing, and delivery of specialty care toward greater value.

Overview of Maryland’s GBR Model

Most specialty care value-based payment models are episode based, meaning that payers identify a target price for the cost of all services provided for a certain episode (eg, joint replacement surgery) or medical condition (eg, kidney disease) over a defined period (eg, 90 days). While some episode-based models have generated savings, their design poses a challenge for health system planning, as many function as stand-alone, payer-specific models that are not integrated clinically or operationally. In contrast, global budget models set population-based payment rates, creating an opportunity to align incentives across both primary and specialty care in a payer-agnostic fashion.

Evaluations of Maryland’s GBR model between 2014 and 2018 revealed reductions in both total and hospital-based expenditures for Medicare beneficiaries and reductions in hospital-based expenditures for commercial enrollees. The CMS did not reprice Maryland hospital payments under Medicare rates when estimating GBR savings, as Maryland does not adhere to national prospective payment systems and because the GBR model standardizes payment rates across payers. In this context, expenditure growth was reduced by 2.8% in Maryland for Medicare beneficiaries, largely driven by savings in hospital outpatient settings ($677 million).

However, utilization outside of hospital-based settings (eg, community-based follow-up care, post-acute care) did not change significantly, likely because physician fee-for-service payments were excluded from the GBR. While the GBR model’s effect on care fragmentation remains unknown, the model’s latest iteration (the total cost of care [TCOC] model, initiated in 2019) emphasizes coordination across the care continuum. Specifically, the TCOC model’s care redesign and episode care improvement programs incentivize nonhospital-based clinicians and facilities to voluntarily partner with hospitals to enhance care quality and efficiency.
Surgical Care as a Case Study for Global Budgets

With 69.4% of surgical expenditures occurring in the inpatient setting and elective surgery accounting for 43% of total gross hospital revenue, surgical care has substantial potential for savings under the GBR model. A recent meta-analysis examined 8 eligible studies of orthopedic, vascular, and general surgical procedures in Maryland. The GBR model was consistently associated with small but statistically significant reductions in index hospitalization spending compared with other states, along with modest improvements on several measures of quality, including complication rates, inpatient mortality, and readmission rates.

However, savings under the GBR model may vary by surgery type. For example, 30-day episode spending for Medicare patients undergoing cancer-directed surgery did not significantly change under the GBR model. This heterogeneity may have several explanations, including differences in the patient mix (eg, comorbidity) and site of care. Evidence from Maryland suggests global budgets may reduce surgical care spending but must be interpreted with the appropriate clinical context.

The GBR model also offers insights into how financial incentives may change the organization and delivery of surgical care. For example, hospitals responded to an all-payer rate setting in Maryland by concentrating complex procedures such as pneumonectomy and gastrectomy in high-volume centers. Because annual budgets are prospectively set under the GBR model, complex procedures may be less financially attractive to low-volume hospitals as the potential for costlier care episodes and lower-quality outcomes there may offset the incremental revenue from performing an additional surgery. This shift may be beneficial for patients' outcomes but may increase travel burden and reduce patient choice. The GBR model was also associated with the migration of lower-acuity cases from inpatient settings to ambulatory surgical centers. Although preliminary evidence suggests overall access to acute hospital-based care improved for historically marginalized populations under the GBR model, it remains unknown how their access to surgery and other types of specialty care evolved under this model.

Lessons for Specialty Care Payment Reforms

Maryland's GBR model has been heralded as a scalable strategy to address the persistent challenge of escalating health care spending. However, evaluations of surgical care under global budgets offer an important reminder of how broad-based payment reforms may have heterogeneous effects across different types of care. Therefore, the GBR experience raises several considerations for CMS's new value-based specialty care strategy.

First, generating savings for specialty care may require payment models that are adapted to specific types of care such as cancer surgery. Furthermore, restricting financial incentives to specific settings can cause savings to shift to unregulated domains, as evidenced by volume migration to ambulatory surgical centers under the GBR model. Moving forward, policy makers should design payment reforms that extend across the care continuum by incorporating site-neutrality provisions in Maryland's TCOC model and other emerging global budget programs.

Second, advancing value-based specialty care will require more nuanced quality measures. Metrics, such as readmissions and emergency department visits, may be limited in their ability to assess specialty care quality. Quality measurement in many specialties is increasingly focused on patient-reported outcomes, which historically have had a limited role in payment model design. Including patient-centered measures would be consistent with CMS's new universal foundation for care quality and stated goal of supporting person-centered specialty care.

Third, value-based specialty care must incorporate explicit considerations of health equity. The GBR model provides 2 potential mechanisms. At the systems level, separating reimbursement from volume can provide systems serving vulnerable populations—such as rural hospitals and safety-net hospitals—with predictable and sustainable financing. To embed equity into future models, policy makers can consider frameworks such as the Global Equity Model, which assesses the success of
payment reforms via improvements in health rather than financial changes alone. For example, the TCOC model embeds disparities indices into its quality measures and sets population health goals for key conditions including diabetes and childhood asthma.

Lastly, the GBR model benefited from Maryland's unique health policy environment, where rate-setting has been enshrined in law for more than 50 years. Replication in other states may necessitate policy innovation. In Oregon, the global budget pilot required the legislature to first establish statewide cost growth targets. Pennsylvania has faced implementation challenges securing participation in global budgets due to market consolidation and the COVID-19 pandemic. Global budget models require multistakeholder alignment to ensure viability.

Advancing the integration of primary and specialty care requires payment models that incentivize meaningful delivery system changes. Evidence from Maryland suggests that global budgets have the potential to constrain spending growth through health care reform, providing a chassis for reorganizing how specialty care is delivered and reimbursed.

REFERENCES


8. Brennan T. Maryland Hospital All-Payer Model: Can It Be Emulated? Health Affairs Forefront; 2022.
